MINISTRY OF HEALTH & WELLNESS

NATIONAL SURVEILLANCE UNIT, NATIONAL EPIDEMIOLOGY BRANCH,
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NATIONAL EPIDEMIOLOGY BRANCH

TUBERCULOSIS CASE INVESTIGATION FORM 1

Form 1 shall be submitted to the Parish Medical Officer of Health, MO(H), within ten (10) weeks of the initial Class 1 Notification to the Health Department and/or Ministry of Health and Wellness of a suspected case of tuberculosis.

SECTION 1 – DEMOGRAPHIC INFORMATION

INITIAL DIAGNOSIS

☐ Tuberculosis

☐ Date of Notification: DD/MM/YYYY

☐ Date Investigation Started: DD/MM/YYYY

PATIENT'S DEMOGRAPHICS

Patient's ID Type:

☐ Driver's License ☐ TRN ☐ Passport ☐ NIN

Patient's ID Number:

First Name:

Patient's ID Number:

Middle Name(s):

Middle Name(s):

Last Name:

Pet Name(s):

Sex Assigned at Birth: ☐ Male ☐ Female

Medical Record Number:

Date of Birth: DD/MM/YYYY

Age:

Country of Residence:

Parish (Jamaica):

House Number, Street Name:

Landmark or directions to address:

Community:

Phone Number:

Email Address:

Occupation:

Name of Workplace/School:

Address of School/Workplace:

Phone Number:

Email Address:

Marital Status:

☐ Married	☐ Visiting union	☐ Widowed	☐ Separated
☐ Common law	☐ Single	☐ Divorced	☐ Other (specify):

Next of Kin

First Name:

Last Name:

Pet Name(s):

Address: Lot/ Street/Community/Parish:

Name of Workplace/School:

Address of School/Workplace:

Phone number:

Email address:

Relationship to the Patient:

☐ Wife	☐ Son	☐ Uncle	☐ Cousin
☐ Husband	☐ Daughter	☐ Aunt	☐ Friend
☐ Mother	☐ Sister	☐ Grandmother	☐ Guardian
☐ Father	☐ Brother	☐ Grandfather	☐ Other (specify):

CLINICAL PROFILE

Has the patient experienced/Is the patient experiencing any of the following symptoms?

SYMPTOM	DATE OF ONSET DD/MM/YYYY	DURATION	SYMPTOM	DATE OF ONSET DD/MM/YYYY	DURATION
☐ Cough			☐ Haemoptysis		
☐ Fever			☐ Chest pain		
☐ Night sweats			☐ Other		
☐ Weight loss			☐ Specify Other:		

Medical History

Pre-existing Conditions

☐ Asthma	☐ Diabetes mellitus	☐ HIV/AIDS	☐ Malignancy
☐ Autoimmune	☐ Heart disease	☐ Hypertension	☐ Sickle cell disease
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Kidney disease	☐ Liver dysfunction	☐ Other Specify Other:

Pregnancy

Is Patient Pregnant: ☐ Yes ☐ No ☐ Unsure	Date of LMP: DD/MM/YYYY
Gestational Age	Trimester: ☐ First ☐ Second ☐ Third

HIV Testing

HIV Screening Test Type:	HIV Confirmatory Test Type:
Date of HIV Screening Test: DD/MM/YYYY	Date of HIV Confirmatory Test: DD/MM/YYYY
HIV Screening Test Results:	HIV Confirmatory Test Results:
☐ Positive ☐ Negative ☐ Indeterminate	☐ Positive ☐ Negative ☐ Indeterminate

Viral load and CD4 count for persons living with HIV

Viral Load result:	copies per millilitre	Date viral load sample taken: DD/MM/YYYY
CD4 Count result:	cells per microlitre	Date CD4 Count sample taken: DD/MM/YYYY

ANTIRETROVIRAL (ARV) MEDICATION HISTORY?

Past or Current Medication	Dosage	Frequency	Date Started (DD/MM/YYYY)	Comments
Tenofovir				
Lamivudine				
Emtricitabine				
Dolutegravir				
Abacavir				
Zidovudine				
Nevirapine				
Lopinavir/ritonavir				
Other (specify):				
OTHER MEDICATION HISTORY:				
Trimethoprim-Sulfamethoxazole/ Co-trimoxazole (Bactrim)				
Other (specify):				
Other (specify):				
Other (specify):				

VACCINATION STATUS

Type of Vaccine	Source of vaccination Information †	BCG Scar seen
BCG		Yes ☐ No ☐

(†) 1=Vaccination card, 2=Health service record, 3=Verbal

Substance Use	Use	Duration
☐ Tobacco		
☐ Ganja/marijuana/cannabis		
☐ Alcohol		
☐ Other substance (please specify): _____		

TRAVEL PROFILE

Travelled in the last 2 years: ☐ Yes ☐ No ☐ Unknown

If travelled: ☐ Domestic Travel ☐ International Travel ☐ Domestic and International Travel

If international travel, fill out the table below:

Country Visited	City Visited	Date Arrived in Country DD/MM/YYYY	Date Departed Country DD/MM/YYYY

Date returned to Jamaica: DD/MM/YYYY

If local travel, fill out the table below:

Address	Parish	Date Arrived DD/MM/YYYY	Date Departed DD/MM/YYYY

Date returned to home address: DD/MM/YYYY

SECTION 2 – DIAGNOSTIC SCREENING

MANTOUX TEST

Mantoux test done: ☐ Yes ☐ No	Mantoux test date: DD/MM/YYYY
Mantoux test reading: _____ mm	Mantoux test interpretation: ☐ Positive ☐ Negative
Reference: Immunocompetent 10 mm or more (positive); Immunocompromised 5 mm or more (positive)	

CHEST X-RAY

Chest X-ray done: ☐ Yes ☐ No	Chest X-ray date:
Chest X-ray description/ findings/result:	
Chest X-ray interpretation: ☐ Positive ☐ Negative	

OTHER INVESTIGATIONS

Other Investigation Done: ☐ Yes ☐ No	Type of Investigation:
Date Investigation Done: DD/MM/YYYY	
Result of Investigation:	

LABORATORY TESTING FOR MYCOBACTERIUM TUBERCULOSIS

Sputum specimen collected	☐ Yes ☐ No		
	Sputum Sample 1	Sputum Sample 2	Sputum Sample 3
Sputum specimen collection date(s)	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Sputum microscopy for acid fast bacilli (AFB) done	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sputum microscopy result (e.g., AFB 1+)			
Sputum microscopy interpretation	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected
	Sputum Culture 1	Sputum Culture 2	Sputum Culture 3
Sputum culture for Mycobacterium tuberculosis done	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sputum culture result			
Sputum culture interpretation	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected
Rifampicin resistance detected on Mycobacterium tuberculosis culture	☐ Resistant ☐ Not resistant ☐ Indeterminate		
Other drug resistance detected on Mycobacterium tuberculosis culture	☐ Yes ☐ No ☐ Not Done		
If yes, specify other drug resistance detected:			
	SputumPCR 1	Sputum PCR 2	Sputum PCR 3
Gene Xpert or polymerase chain reaction (PCR) done	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Gene Xpert or polymerase chain reaction (PCR) results interpretation	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected	☐ Positive ☐ Negative ☐ Indeterminate ☐ Sample rejected
Rifampicin resistance detected on Gene Xpert or polymerase chain reaction (PCR)	☐ Resistant ☐ Not resistant ☐ Indeterminate	☐ Resistant ☐ Not resistant ☐ Indeterminate	☐ Resistant ☐ Not resistant ☐ Indeterminate

SECTION 3 – ANTI-TUBERCULOSIS TREATMENT INITIATION: INTENSIVE PHASE

Date started Intensive **Phase of anti-TB treatment:** DD/MM/YYYY	Date completed **Intensive Phase of anti-TB treatment:** DD/MM/YYYY
Name of hospital	
Date of admission: DD/MM/YYYY	Date of discharge: DD/MM/YYYY
Directly Observed Therapy (DOT): ☐ Yes ☐ No	

ANTI-TUBERCULOSIS TREATMENT

Past or Current Medication	Dosage	Actual Duration Received (weeks)	Comments
☐ Isoniazid			
☐ Rifampicin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other			
☐ Other			

SECTION 4 – SOCIAL ASSESSMENT

LIVING ARRANGEMENT

☐ Lives alone	☐ Lives with partner	☐ Lives with family
☐ Lives with friends	☐ Other (Specify Other):	
☐ Number of household members: _____		

DWELLING TYPE

☐ Separate House-Detached	☐ Apartment Building	☐ Townhouse
☐ Other Attached	☐ Part of Commercial Building	☐ Improvised Housing Unit
☐ Homeless	☐ Non-response	☐ Other (Specify):
Number of rooms:	Number of bedrooms:	Number of persons per bedroom:

Water Supply:	☐ Good	☐ Fair	☐ Poor
Ventilation:	☐ Good	☐ Fair	☐ Poor
Cleanliness:	☐ Good	☐ Fair	☐ Poor

FOOD AND NUTRITION SUMMARY

Milk supply: ☐ Pasteurised ☐ Unpasteurised

WORKPLACE ARRANGEMENT

Risk Level (Crowding): ☐ Low ☐ Medium ☐ High

Notes (e.g., about contacts; industry):

SECTION 5 – CONTACT TRACING

First Name				
Last Name				
D.O. B DD/MM/YYYY				
Sex	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Relation to index				
Address				
Phone Number				
Symptoms	☐ Cough ☐ Fever ☐ Night Sweats ☐ Weight Loss ☐ Asymptomatic	☐ Cough ☐ Fever ☐ Night Sweats ☐ Weight Loss ☐ Asymptomatic	☐ Cough ☐ Fever ☐ Night Sweats ☐ Weight Loss ☐ Asymptomatic	☐ Cough ☐ Fever ☐ Night Sweats ☐ Weight Loss ☐ Asymptomatic
Previous BCG	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mantoux Date DD/MM/YYYY				
Mantoux Reading				
Further Evaluation	☐ Chest X-ray ☐ Sputum collected ☐ Other	☐ Chest X-ray ☐ Sputum collected ☐ Other	☐ Chest X-ray ☐ Sputum collected ☐ Other	☐ Chest X-ray ☐ Sputum collected ☐ Other
Evaluation Date DD/MM/YYYY				
Findings				
Contact Classification Suspected TB	☐ Suspected ☐ Previously Treated ☐ Latent TB ☐ Discarded	☐ Suspected ☐ Previously Treated ☐ Latent TB ☐ Discarded	☐ Suspected ☐ Previously Treated ☐ Latent TB ☐ Discarded	☐ Suspected ☐ Previously Treated ☐ Latent TB ☐ Discarded
Comments				

TUBERCULOSIS CASE INVESTIGATION FORM 1

SECTION 6 (TB FORM 1) - CLASSIFICATION

Final Classification of Case

- ☐ Confirmed
- ☐ Pending
- ☐ Inconclusive
- ☐ Discarded

Confirmation Category

- ☐ Bacteriologically confirmed
- ☐ Clinically diagnosed

Anatomical site

- ☐ Pulmonary
- ☐ Extra-pulmonary

Drug resistance

- ☐ None
- ☐ Rifampicin resistant
- ☐ Multi-drug resistant
- ☐ Extremely drug-resistant

Previous TB Treatment

Previously treated for tuberculosis?
☐ Yes ☐ No

Relapse case?
☐ Yes ☐ No

Treatment after lost to follow-up?
☐ Yes ☐ No

Treatment after failure?
☐ Yes ☐ No

Treatment status for current diagnosis

- ☐ Completed
- ☐ Not completed

Status for current diagnosis

- ☐ Admitted for Intensive Phase
- ☐ Discharged from Intensive Phase
- ☐ Started Continuation Phase
- ☐ Lost to follow-up
- ☐ Died Date of death: DD/MM/YYYY

REVIEW AND SIGNATURE

Comments

Investigator's Details

Date Investigation Completed (DD/MM/YYYY):
First Name: Last Name
Professional Group:
Phone number: Email Address:
Name of Institution:
Parish: Community:
Office Number/Street Name:
Health Region:

Investigator's Signature: Date signed by Investigator (DD/MM/YYYY):

Name of Parish MO(H): Signature of MO(H) Date signed by MO(H), (DD/MM/YYYY)